Dept of Labor & Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

STATEMENT FOR HOME NURSING SERVICES

DO NOT WRITE IN SPACE >

Worker's full name Last	First	Middle	SSN (ID only)	Claim Number
Address			Employer's Name	
City	State	ZIP	Reimburse Claimant ☐ Yes ☐ No	
Date of Injury	Name of referring physician or other source		Referring physician provider number	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable
1.
2.
3.
4.
5.

For glasses, advise if old Rx was available ☐ Yes ☐ No

Give hospitalization date for inpatient services
Admitted _____
Discharged _____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.
CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS *	TOS *	PROC CODE	MOD CODE	Describe procedures, medical services or supplies furnished. Attach lab reports, X-ray findings and any special services	Dental Ttooth Number	Home Nursing No. of hrs/day	Home Nursing Hourly/ Day rate	GLASSES OLD RX OD	GLASSES OLD RX OS	GLASSES NEW RX OD	GLASSES NEW RX OS	CHARGES $ C	Unit	T O DATE OF SERVICE
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															
13.															

Submission of this bill certifies the material furnished, service provided, expense incurred or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid.
Signature: Bill date:

Provider or Supplier name	Provider number	Total Charge
Address		Phone Number
City State ZIP+4		Your Patient's Account Number
Federal tax ID number ☐ EIN ☐ SSN		

Remarks:

RESET

* Place of Service (POS) and Type of Service (TOS) codes on page 2

INSTRUCTIONS FOR COMPLETING HOME NURSING SERVICES STATEMENT

1. **INJURED WORKER'S NAME:** Injured worker's full name, last name first.
2. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the worker's name is common.
3. **CLAIM NUMBER:** For the injured worker receiving services.

INDUSTRIAL INSURANCE

Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M , N, P, X, Y or double alpha followed by 5 digits". Crime Victim claim numbers are six digits preceded by a "V" or five digits preceded by a "VA, VB, VC, VH, VJ or VK". Department of Energy claims are seven digits with no preceding letter.

Send bills for Industrial Insurance claims to:
Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Send bills for Crime Victims claims to:
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location.

SELF INSURANCE

Self-Insurance claim numbers are six digits preceded by an "S, T or W". Bills for **all** self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

4. **ADDRESS:** The injured worker's most current address.
5. **EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
6. **REIMBURSE CLAIMANT:** Place an "X" in the applicable box. If payment should be made to the claimant, indicate the amount paid.
7. **DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services.
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Department of Labor and Industries provider account number of the referring physician. The number may be obtained from the referring physician.
10. **DIAGNOSIS:** Not applicable.
11. **FOR GLASSES:** Not applicable.
12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
13. **REFUND CERTIFICATION - FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
14. **ITEMIZATION OF SERVICES AND CHARGES:**
    - A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (i.e., home nursing care, attendant care) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    - B. **PLACE OF SERVICE:** A complete list of Place of Service (POS)) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
    - C. **TYPE OF SERVICE:** Enter "9 (nine)" on each line of service.
    - D. **PROCEDURE CODE**: Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries. Enter the appropriate code and describe the procedure. **Enter only one code per line.**
    - E. **CODE MODIFIER:** Not applicable.
    - F. **DENTAL:** Not applicable.
    - G. **HOME NURSING:**
      Number of Hours or Days: Enter number of hours per day or number of days per month.
      Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home nursing services provided.
    - H. **GLASSES:** Not applicable.
    - I. **CHARGES:** Total line item charge.
    - J. **UNIT:** The total hours if an hourly rate was entered in the home nursing column (item "G") or total of days if a daily rate was entered in the home nursing column (item "G").
15. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER**: The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
16. **PROVIDER NUMBER**: Identification number for the provider which is designated by the Department of Labor and Industries.
17. **TOTAL CHARGE**: Total of **all** charges for services provided.
18. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
19. **BILL DATE**: The date our billing was prepared.
20. **TAX IDENTIFICATION NUMBER**: The provider taxpayer identification number for IRS (Internal Revenue Service) reports.
21. **REMARKS:** Any further information necessary to explain your charge.

ATTACHMENTS

Must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.

The following attachment **is not** acceptable: Office Visit Slips.

REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "**Rebill**" on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

03. School
04. Homeless Shelter
05. Indian Health Service Free-standing Facility
06. Indian Health Service Provider-based Facility
07. Tribal 638 Provider-based Facility
08. Tribal 638 Provider-based Facility
11. Office
12. Patient's Home
13. Assisted Living Facility
14. Group Home
15. Mobile Unit
20. Urgent Care Facility
21. Inpatient Hospital
22. Outpatient Hospital
23. Emergency Rm - Hospital
24. Ambulatory Surgical Ctr
25. Birthing Ctr
26. Military Trmt Facility
31. Skilled Nursing Facility
32. Nursing Facility
33. Custodial Care Facility
34. Hospice
41. Ambulance - Land
42. Ambulance - Air or Water
49. Independent Clinic
50. Federally Qualified Hlth Ctr
51. Inpatient Psychiatric Facility
52. Psychiatric Facility Partial Hospitalization
53. Community Mental Health Ctr
54. Intermediate Care Facility/Mentally Retarded
55. Residential Substance Abuse Trmt Facility
56. Psychiatric Residential Trmt Ctr
57. Non-residential Substance Abuse Trmt Facility
60. Mass Immunization Center
61. Comprehensive Inpatient Rehabilitation Facility
62. Comprehensive Outpatient Rehabilitation Facility
65. End Stage Renal Disease Trmt Facility
71. State or Local Public Health Clinic
72. Rural Hlth Clinic
81. Independent Laboratory
99. Other Unlisted Facility